

# Instructions and Important Information Keep This Paper!

#### Instructions

- Section 1. Information on parents/adults and pregnant women in the household please fill in all the information about the biological, caretaker relative, adoptive or stepparents that live with the children and pregnant women for whom you are applying and/or about the pregnant woman for whom you are requesting coverage.

  Citizenship requirements apply to pregnant women applying for coverage. Please see examples in Section 2, on this page, of what paperwork must be included with your application if you are not a U.S. citizen.
- Section 2. Information About Children please fill in information about all the children living in the home (even if you are not applying for that child). All fields must be completed except racial heritage. Empty fields may cause the application to be returned for completion, which could delay coverage. If you are not a U.S. citizen, you must send paperwork with your application that describes your alien status. The Bureau of Citizenship and Immigration Service (BICS) has several types of documents that an alien may use to verify your status. Examples of these documents include: Form I-151 or I-551—Alien Registration or a Re-entry Permit; Form I-94—Arrival/Departure Record; Form I-688—Temporary Resident Card; Forms I-688A (Employment Authorization Card) and I-689A show that an alien has applied for admission; Form G-641—Application for Verification of Information from BICS Records; court order stating that documentation has been withheld pursuant to Section 243(h) of the Immigration and Nationality Act.
- **Section 3.** Income Information for employment information, please add together monthly income amounts from each job if you have more than one job. Please note for all households, especially self-employed households, we may request additional information to understand your total gross income. Please list the monthly amount of all types of income received by anyone in the household.
- **Section 4.** Certification and Authorization By signing here you acknowledge that you have provided correct and true information on the entire application.

Section 5. Please Sign and Date Your Application – please sign your application and list the date you are signing it.

\*Any application missing the signature and any information will be returned. If the signature is missing, you will be asked to sign and resubmit your application. If you have missing information, you will be asked to complete the missing information and resubmit your application.

### What is CoverKids?

CoverKids is a low-cost health coverage program for children and pregnant women who meet eligibility guidelines. Eligible individuals must:

- Be between birth and under the age of 19 on the date of application or a pregnant woman.
- Have no health insurance coverage (for example, private insurance, state-sponsored health insurance) and not be eligible for TennCare. Applications are first reviewed for possible TennCare eligibility. If it appears that a child may be eligible for TennCare, the applicant will be asked to complete a TennCare application. Families can receive help to complete the TennCare application.
- Be a citizen of the United States, or an eligible immigrant.
- Be a Tennessee resident.

### **Social Security Numbers**

You must tell us about the citizenship and immigration status of each child or pregnant woman for whom CoverKids coverage is being requested. You must also give us the Social Security Number (SSN) or proof that application for an SSN was made for each child for whom coverage is being requested. The SSN will be verified. For children approved without an SSN, an SSN must be submitted within 3 months of when coverage begins. \*For parents/adults, it is optional to provide your SSN and failure to voluntarily provide your SSN will not affect the eligibility of your child.

Important: Signing the CoverKids application means that you understand the application, including the statements under Sections 4 and 5 and the following statements. It also means you know what happens if you break the rules.

- I understand that the law provides penalties for persons not being completely truthful and persons hiding facts about things like income, home address and other insurance.
- I understand that if I let anyone else use my CoverKids card, I will be committing fraud and could pay for the other person's medical bills.
- I understand that if the Office of the Inspector General or any other state agency contacts me about CoverKids fraud or abuse, I must help them. If I am found guilty of fraud, penalties will be enforced.



ئەگەر تو پنتقى ھارىكارىي بى بو تنگەھشتنا قى فۆرمى يان ھەر نامەكى دەربارەى (كەقەر كىدن) (CoverKids) بىكەر تو پنتقى ھارىكارىي بىكە بى 9906 - 313 كاناشىقل يان بى 3413-626-626 كادەرقەى ناشقل. ئەق تەلەفۆنە خۆراييە.

كوردى – سۆرانى Kurdish - Sorani

ئەگەر يارمەتىت پيۆيستە بۇ تىڭگەيشتنى ئەم فۆرمە يان ھەر نامەيەكى تر لە (كەڤەر كىدن) (CoverKids) بە كوردى، پەيوەندى بكـه بـە 9906 – 313 لە ناو ناشــڤل يان بـە 3413-626-626 لە دەرەوەى ناشڤل. ئەم تەلەفۆنە بە خۆراييە.

Arabic العربية

إذا كنت تحتاج الى مساعدة لفهم هذه الاستمارة أو اية رسائل بخصوص كوفر كدز (CoverKids) بالعــربيــة، رجاءً اتصــل بــ 316-626-626 من خارج ناشــفل. هـــذه المكالمة مجانية.

## Spanish Español

Si Ud. necesita ayuda con la aplicación, llámenos al 1-866-626-3409. La llamada es gratis. Los servicios del intérprete del idioma están disponibles en muchos idiomas incluyendo Español.

### Somali Soomaali

Hadii aad rabtid inaad ku fahamtid af Soomaali waraaqahan CoverKids, fadlan la xidhiidh 313-9894 Nashville gudaheeda, dibadeedana 1-877-652-3054 oo bilaash ah.

### Bosnian Bosanski

Ako vam treba pomoć u razumjevanju ove molbe ili bilo kojeg CoverKids pisma na Bosanskom/Srpskom/Hrvatskom molimo zovite 313-9382 ili 1-877-652-3069 izvan Nashville. Ovaj poziv se ne plaća.

## Vietnamese Tiếng Việt

Nếu quý vị cần giúp đỡ để hiểu thêm chi tiết về lá đơn hoặc lá thư về chương trình của CoverKids bằng Việt Ngữ, thì xin gọi số 313-9899 trong vùng Nashville, hoặc gọi số miễn phí 1-800-269-4901.



# **Application**

**CoverKids** is a low-cost health coverage program for children under the age of 19. **Please fill out this entire application.** If a question does not apply to you, write N/A in that space.

Note: If you are pregnant and under 19, you have the option of applying for yourself without reporting your parents' information or you can apply as part of your family.

# Section 1: Information on Parents/Adults

|                   |                       |             | &       | Pr      | egr      | ant       | W           | ome                      | n           | in    | Н          | ous    | se   | ho     | ld     |       |        |      |      |        |      |        |          |          |         |
|-------------------|-----------------------|-------------|---------|---------|----------|-----------|-------------|--------------------------|-------------|-------|------------|--------|--|--------|--------|-------|--------|------|------|--------|------|--------|----------|----------|---------|
|                   | Pare                  | nt ma       | y be a  | a biolo | ogical   | parent    | , an a      | doptiv                   | e pa        | rent, | step       | pare   | nt, c  | r ca   | retak  | cer r | elati  | ve.  |      |        | _    |        |          |          |         |
| Parent/Adult 1:   | Name:                 |             |         |         |          |           |             |                          |             |       |            |        |  |        |        |       |        |      |      |        | ]    |        |          |          |         |
|                   | First                 |             |         |         |          |           | M.I         | l. Las                   | st          |       |            |        |  |        |        |       |        |      |      |        |      | Suffix | (III, IV | ′, Jr. o | or Sr.) |
|                   | Date of Birth:        |             | $/\Box$ |         |          |           | Se          | ex: 🔲 N                  | Лale        | □ F   | emal       | e *s   | Socia  | al Se  | curity | / Nu  | mbe    | r:   |      |        |      |        |          |          |         |
|                   |                       |             | MM/D    | D/YY    | ΥY       |           | (check      | one)                     |             |       |            |        |  |        |        |       |        |      |      |        |      |        |          |          |         |
|                   | Street Address:       |             |         |         |          |           |             |                          |             |       |            |        |  |        |        |       |        |      | T    | T      |      |        | T        |          |         |
|                   | Otroct Address.       | Nı          | umber   | and s   | treet, i | includin  | g apar      | rtment                   | numl        | oer   |            |        |  |        | -      |       |        |      |      |        |      |        |          |          |         |
|                   |                       |             |         |         |          |           |             |                          |             |       |            |        |  |        |        |       |        |      | T    | Τ      |      |        | 1        |          |         |
|                   | '                     | Ci          | ty      |         |          |           |             | Sta                      | ate         |       |            |        |  |        | Zip    | o Co  | de     |      |      |        |      | С      | ount     | y        |         |
|                   | Mailing Address:      |             |         |         |          |           |             |                          |             |       |            |        |  |        |        |       |        |      |      |        |      |        |          |          |         |
|                   | (If different from    | street      | addre   | ss)     |          | ' '       | Nur         | nber a                   | nd st       | reet, | inclu      | ding   | ара  | rtmer  | nt nu  | mbe   | r      | '    |      |        |      |        |          |          |         |
|                   |                       |             |         |         |          |           |             |                          |             |       |            |        |  |        |        |       |        |      | T    | T      |      |        | 1        |          |         |
|                   | '                     | Ci          | ty      |         |          |           |             | Sta                      | ate         |       | _          |        |  | -      | Zip    | o Co  | de     |      |      |        |      | С      | ount     | y        |         |
|                   | Home Telephone        | . $\square$ |         |         |          |           |             |                          | \/\/c       | ork T | eleph      | one.   | . $	extstyle 	ext$ |        |        |       |        |      |      |        |      |        |          |          |         |
|                   | Tiome receptions      |             |         |         |          |           |             | _                        | ***         | ,,,,, | СІСРІ      | 10110. | _  |        |        |       |        |      |      |        | _    |        |          |          |         |
|                   | Other Telephone:      |             |         |         |          |           |             |                          |             |       |            |        |  |        |        |       |        |      |      |        |      |        |          |          |         |
|                   | Name of Esseless      |             |         |         |          |           |             |                          |             |       |            |        |  |        |        |       |        |      | Т    | Т      | П    | $\Box$ | Т        |          |         |
|                   | Name of Employe       | er:         |         |         |          |           |             |                          |             |       |            |        |  |        |        |       |        |      |      |        | ш    |        |          | Ш        | ш       |
|                   | Race/Ethnic Back      | kgrou       | nd: (ch | neck o  | ne)      | ☐ Ame     |             |                          |             |       |            |        |  |        |        |       |        |      |      |        |      | ispa   | nic/La   | atino    | o<br>—  |
|                   | What is your fam      | ily's p     | referre | ed lang | guage    | ? 🖵 Er    | nglish      | ☐ Spa                    | anish       |       | Other      |        |  |        |        |       | _      |      |      |        |      |        |          |          |         |
|                   | Do you or your sp     | oouse       | work    | for sta | ite or I | ocal go   | vernm       | ent?                     | ☐ Ye        | s 🗆   | <b>N</b> o |        |  |        |        |       |        |      |      |        |      |        |          |          |         |
|                   | Have you receive      | d ass       | istanc  | e from  | Fami     | lies Firs | t in the    | e last f                 | our n       | nonth | ns?        | ☐ Ye   | es [   | ☐ No   | )      |       |        |      |      |        |      |        |          |          |         |
|                   | Are you pregnant      | i? 🗆        | Yes     | ☐ No    | o (If    | Yes, ple  | ease c      | complet                  | te the      | He    | althyT     | NBa    | bies   | ques   | stion  | s.)   |        |      |      |        |      |        |          |          |         |
| Parent/Adult 2:   | Name: First           |             |         |         |          |           | M.I         | l. Las                   | st          |       |            |        |  |        |        |       |        |      | Ι    |        | ] [  | Suffix | (III, IV | /, Jr. c | or Sr.) |
|                   | Date of Birth:        |             | / [     | D/YY    | YY       |           | Se (check   | ex: \( \sum_{\text{N}}\) | //ale       | □F    | emal       | e * 9  | Socia  | al Se  | curity | / Nu  | mbe    | r: [ | I    |        |      |        |          |          |         |
|                   | Home Telephone        | : [         |         |         |          |           |             |                          | Wo          | ork T | eleph      | one:   | : [  |        |        |       |        |      |      |        |      |        |          |          |         |
|                   | Other Telephone:      |             |         |         |          |           |             |                          |             |       |            |        |  |        |        |       |        |      |      |        |      |        |          |          |         |
|                   | Name of Employe       | er:         |         |         |          |           |             |                          |             |       |            |        |  |        |        |       |        |      | L    | L      |      |        |          |          |         |
|                   | Race/Ethnic Back      | kgrou       | nd: (ch | neck o  | ne)      | ☐ Ame     |             |                          |             |       |            |        |  |        |        |       |        |      |      |        |      | Hispa  | nic/L    | atino    | o<br>   |
|                   | Is this parent living | ng in t     | he hou  | usehol  | d? □     | Yes       | □No         |                          |             |       |            |        |  |        |        |       |        |      |      |        |      |        |          |          |         |
|                   | Do you or your sp     | oouse       | work    | for sta | ite or I | ocal go   | vernm       | ent?                     | ☐ Ye        | s [   | ) No       |        |  |        |        |       |        |      |      |        |      |        |          |          |         |
|                   | Have you receive      | d ass       | istanc  | e from  | Fami     | lies Firs | t in the    | e last f                 | our n       | nonth | ns?        | ☐ Ye   | es [   | □No    | )      |       |        |      |      |        |      |        |          |          |         |
|                   | Are you pregnant      | i? 🗆        | Yes     | □ No    | o (If    | Yes, ple  | ease c      | complet                  | te the      | e Hea | althyT     | NBa    | bies   | ques   | stion  | s.)   |        |      |      |        |      |        |          |          |         |
|                   |                       |             |         |         | Н        | EALTH'    | Y <b>TN</b> | <b>₿</b> Babi            | es <b>G</b> | ue    | stio       | ns     |  |        |        |       |        |      |      |        |      |        |          |          |         |
| 1. You must have  | your doctor send      | a lett      | er stat | ing yo  | u are    | pregnar   | nt. (Ple    | ease se                  | end a       | сор   | y of tl    | he d   | octor  | 's sta | atem   | ent v | with : | our/ | appl | icatio | on). |        |          |          |         |
| a. What is your d | lue date?             | / [_        |         |         |          |           |             | b. How                   | / mai       | ny ba | abies      | are y  | you c  | carryi | ng?    |       |        |      |      |        |      |        |          |          |         |

|   | HEALTHY <b>TN</b> Babies Questions (Cont.)  |  |  |  |  |  |  |  |
|---|---|--|--|--|--|--|--|--|
| (If No, you n                           | .S. Citizen? ☐ Yes ☐ No nust send a copy of the document that indicates your legal status in the U.S. with your application).   |  |  |  |  |  |  |  |
| (If Yes, copy                           | Do you have health insurance?  \( \textstyle \text{Yes} \) No  Yes, copy the front and back of each insurance card and send it with your application)   |  |  |  |  |  |  |  |
|   | b. Does your health insurance include maternity benefits (prenatal and delivery care)?  |  |  |  |  |  |  |  |
|   | ave CoverTN Insurance?  |  |  |  |  |  |  |  |
| (If Yes, a wr<br>and explain            | had health insurance that ended in the past 3 months?   |  |  |  |  |  |  |  |
| 5. a. Are you e                         | nrolled in TennCare or TennCare Standard?   |  |  |  |  |  |  |  |
| b. If Yes, whi                          | ch one? ☐ TennCare ☐ TennCare Standard  |  |  |  |  |  |  |  |
|   | Section 2: Information About Children  I children living at home, even if you are not applying for that child. If you have more than 3 children, please complete ges answering similar series of questions below.  Name |  |  |  |  |  |  |  |
|   | First  M.I. Last  Suffix (III, IV, Jr. or Sr.)  Date of Birth:  MM/DD/YYYY  (check one)  Sex: Male Female Social Security Number: (required)  |  |  |  |  |  |  |  |
|   | Race/Ethnic Background (check one) American Indian/Alaska Native Asian Black/African-American Hispanic/Latino  Native Hawaiian/Other Pacific Islander White/Caucasian Other   |  |  |  |  |  |  |  |
| Are you                                 | Relationship to Parent #1:  |  |  |  |  |  |  |  |
| applying for<br>CoverKids               | Relationship to Parent #2:  |  |  |  |  |  |  |  |
| for this child?  Yes No                 | Child's Mother's Name First M.I. Last   |  |  |  |  |  |  |  |
| (If No, do not include the child's SSN) | Child's Father's Name First M.I. Last   |  |  |  |  |  |  |  |
| Child 2:                                | Name First M.I. Last Suffix (III, IV, Jr. or Sr.)   |  |  |  |  |  |  |  |
|   | Date of Birth: Sex: Male Female Social Security Number: (check one) (required)  |  |  |  |  |  |  |  |
|   | Race/Ethnic Background (check one)  American Indian/Alaska Native Asian Black/African-American Hispanic/Latino  Native Hawaiian/Other Pacific Islander White/Caucasian Other  |  |  |  |  |  |  |  |
| Are you                                 | Relationship to Parent #1:  |  |  |  |  |  |  |  |
| applying for CoverKids                  | Relationship to Parent #2:  |  |  |  |  |  |  |  |
| for this child?  Yes No                 | Child's Mother's Name   |  |  |  |  |  |  |  |
| (If No, do not include the child's SSN) | Child's Father's Name  First M.I. Last  Child's Father's Name  First M.I. Last  |  |  |  |  |  |  |  |
| Child 3:                                | Name First M.I. Last Suffix (III, IV, Jr. or Sr.)   |  |  |  |  |  |  |  |
|   | Date of Birth: Sex: Male Female Social Security Number: MM/DD/YYYY (check one) (required)   |  |  |  |  |  |  |  |
|   | Race/Ethnic Background (check one) American Indian/Alaska Native Asian Black/African-American Hispanic/Latino  Native Hawaiian/Other Pacific Islander White/Caucasian Other   |  |  |  |  |  |  |  |
| Are you applying for                    | Relationship to Parent #1:  |  |  |  |  |  |  |  |
| CoverKids for this child?               | Relationship to Parent #2:  |  |  |  |  |  |  |  |
| Yes No (If No, do not                   | Child's Mother's Name First M.I. Last   |  |  |  |  |  |  |  |
| include the child's SSN)                | Child's Father's Name   |  |  |  |  |  |  |  |
|   | First M.I. Last   |  |  |  |  |  |  |  |

### Section 2: Information About Children (Cont.)

### QUESTIONS—Please check one (Y or N)

|    |  | Child 1                       | Child 2                       | Child 3                        |
|----|--|-------------------------------|-------------------------------|--------------------------------|
| 1. | Is this child's address the same as the parent's/adult's? (Each child and pregnant woman must apply from his or her home address).   | ☐ Yes ☐ No                    | ☐ Yes ☐ No                    | ☐ Yes ☐ No                     |
| 2. | Is this child a U.S. citizen? (If No, you must send a copy with your application of the document that indicates this child's legal status in the U.S.).  | ☐ Yes ☐ No                    | ☐ Yes ☐ No                    | ☐ Yes ☐ No                     |
| 3. | Does this child live in Tennessee?   | ☐ Yes ☐ No                    | ☐ Yes ☐ No                    | ☐ Yes ☐ No                     |
| 4. | Does this child have health insurance? (If Yes, copy the front and back of each insurance card and send it with your application).   | ☐ Yes ☐ No                    | ☐ Yes ☐ No                    | ☐ Yes ☐ No                     |
| 5. | a. Has this child had health insurance that ended in the past 3 months? (If Yes, a written statement must be sent with your application, listing the policy number and insurance company name and explaining why the insurance ended). | ☐ Yes ☐ No                    | ☐ Yes ☐ No                    | ☐ Yes ☐ No                     |
|    | b. Date Insurance Ended:   | MM/DD/YYYY                    | MM/DD/YYYY                    | MM/DD/YYYY                     |
| 6. | Does this child have Children's Special Services?  | ☐ Yes ☐ No                    | ☐ Yes ☐ No                    | ☐ Yes ☐ No                     |
| 7. | We want to make sure that your child is considered for all coverage that may be right for them. Please answer the following questions:   |                               |                               |                                |
|    | a. Does this child have a diagnosed medical condition (including pregnancy) or disability? (If the child is pregnant, please fill out the HealthyTNBabies Questions).  | ☐ Yes ☐ No                    | ☐ Yes ☐ No                    | ☐ Yes ☐ No                     |
|    | b. If Yes, what is the name of the condition or disability?  |                               |                               |                                |
|    | c. Have you been denied for Supplemental Security Income (SSI) for this child?   | ☐ Yes ☐ No                    | ☐ Yes ☐ No                    | ☐ Yes ☐ No                     |
| 8. | Does this child have a parent that works for State or local government?  | ☐ Yes ☐ No                    | ☐ Yes ☐ No                    | ☐ Yes ☐ No                     |
| 9. | a. Do you receive child support for this child?  | ☐ Yes ☐ No                    | ☐ Yes ☐ No                    | ☐ Yes ☐ No                     |
|    | b. If Yes, what amount do you receive per month per child?   |                               |                               |                                |
| 10 | . a. Does this child have TennCare or Tenncare Standard?   | ☐ Yes ☐ No                    | ☐ Yes ☐ No                    | ☐ Yes ☐ No                     |
|    | b. If Yes, which one?  | ☐ TennCare☐ Tenncare Standard | ☐ TennCare☐ Tenncare Standard | ☐ TennCare ☐ Tenncare Standard |
|    | c. Date TennCare Ended   | MM/DD/YYYY                    | MM/DD/YYYY                    | MM/DD/YYYY                     |
|    | d. Have you filed an appeal or plan to file an appeal?   | ☐ Yes ☐ No                    | ☐ Yes ☐ No                    | ☐ Yes ☐ No                     |

If you need help with your application, call 1.866.620.8864 (This is a free call.)

◆ Fax 1-866-913-1046 ◆ TTY 1-866-447-0272 (These are free calls.)

Language interpreter services are available in many languages including Spanish. Si Ud. necesita ayuda con la aplicacion, llamenos. La llamada es gratis

Hours: Monday through Friday 7 AM to 6 PM (Central Standard Time)

### **Section 3: Income Information**

(Add wages together for two or more jobs.) (Attach additional pages, if needed.)

| WA | G | ES: |
|----|---|-----|
|----|---|-----|

| Family Member Name<br>(First and Last Name) | Are you employed? | Monthly income from work (tips included) |
|---|-------------------|--|
|   | □Yes □No          | \$                                       |
|   | □Yes □No          | \$                                       |

#### **SELF-EMPLOYMENT:**

| Name of Self-Employed Person<br>(First and Last Name) | Monthly<br>income<br>from work | Monthly<br>allowable federal<br>tax deductions* |
|---|--------------------------------|---|
|   | \$                             | \$  |
|   | \$                             | \$  |

### **OTHER INCOME:**

\*Such as estimated tax, which includes tax you pay to the Federal government, and self-employment taxes.

- 1. Unemployment Benefits
- 6. Interest Income
- 11. Supplemental Security Income (SSI)

- 2. Worker's Compensation
- 7. Rental Income8. Strike Benefits
- 12. Retirement Survivors Disability Insurance (RSDI)13. Families First

- Military Allotment
   Veteran's Benefits
- 9. Investment Income
- 14. Social Security Benefits

- 5. Retirement Benefits
- 10. Cash from Friends/Family
- 15. Other (Please specify \_\_\_\_\_

| List household members who receive income (First and Last Name) | Type of Income (from above list) | If RSDI Income,<br>please enter<br>claim number | Monthly Gross<br>Income<br>(before taxes) |
|---|----------------------------------|---|---|
|   |                                  |   | \$  |
|   |                                  |   | \$  |
|   |                                  |   | \$  |
|   |                                  |   | \$  |
|   |                                  |   | \$  |

**Rental Property:** Do not complete this section unless you reported rental income. (These are your monthly expenses for the rental of property that you own and rent to others.)

| Name of rental property owner<br>(First and Last Name) | Monthly amount of<br>expenses for rental<br>property you own |
|--|--|
|  | \$   |

Child Support: (If you pay child support for children not living with you, write each child's name and the amount of child support

you pay each month.)

| Child's Name          | Parent/Adu | ılt 1 | Parent/ | Adult 2 | Monthly     |
|-----------------------|------------|-------|---------|---------|-------------|
| (First and Last Name) |            |       |         |         | amount paid |
|                       | □Yes □     | No    | □Yes    | □No     | \$          |
|                       | □Yes □     | No    | □Yes    | □No     | \$          |
|                       | □Yes □     | No    | □Yes    | □No     | \$          |

Child Day Care: (If you pay child day care for children living with you so you can work, write each child's name.)

| Child's Name          | Parent/ | Adult 1 | Parent/Adult |     |
|-----------------------|---------|---------|--------------|-----|
| (First and Last Name) |         |         |              |     |
|                       | □Yes    | □No     | □Yes         | □No |
|                       | □Yes    | □No     | □Yes         | □No |
|                       | □Yes    | □No     | □Yes         | □No |

### Section 4: Certification and Authorization

I understand that signing this authorization is required for enrollment in this health plan.

I understand that when the Division of Insurance Administration pays the cost of medical services, any right to recover costs from a third person or public or private contractor, except Medicare, is transferred to the Department. Payment of any recovery under such right is to be made directly to the State of Tennessee, Division of Insurance Administration or its agent.

I understand that if I get more benefits than I am entitled to through my fault, I may have to repay any extra benefits received.

I understand that this application is for one health benefit program and is not a TennCare application. I understand that I will be screened for TennCare first before a determination of CoverKids eligibility will occur.

The Division of Insurance Administration will not discriminate against any individual or group because of race, sex, religion, color, national or ethnic origin, age, disability, or military service. I understand that if I wish to file a discrimination complaint, I can contact the Director of Non-Discrimination Compliance by calling 1-800-342-3145 ◆ TTY 1-866-447-0272.

I understand that enrollment in CoverKids will be continuous for 12 months unless any of the following occur: The child turns age 19; the child or pregnant woman gains access to state-sponsored health insurance through a family member's or their own employment with a public agency; the CoverKids beneficiary is enrolled into individual or group coverage; 60 days after the pregnancy ends for a woman enrolled because of pregnancy; the family fails to pay CoverKids premiums; an audit or periodic review indicates that a CoverKids beneficiary is not eligible; the CoverKids beneficiary dies; or for other reasons.

I understand that computer crosschecking may be used to verify information I have provided on this application.

I understand that I can report suspected fraud and abuse to the Office of the Inspector General Fraud and Abuse hotline by calling toll-free 1-800-433-3982.

I understand that I have the right to appeal an enrollment decision. I will be notified of my rights if my application is denied for any reason.

If you are a person with a hearing or speech disability and you need help with reading or writing to complete this application, under the Americans with Disabilities Act, you are invited to make your needs known by calling 1-866-620-8864 ◆ Fax 1-866-913-1046 ◆ TTY 1-866-447-0272. Language interpreter services are available at no cost.

# Section 5: Please Sign and Date Your Application

I declare under penalty of perjury that the answers and information I have given on this form are true, and that all persons applying for or receiving coverage are U.S. citizens or eligible immigrants. I understand the rules and information given to me. I will provide information that proves my statements if asked. I give CoverKids permission to get proof of the information I have provided on this application. I understand I must report any changes about our living situation, other than income changes, within 10 days.

|                     |                | Date: |  |
|---------------------|----------------|-------|--|
|                     | Parent/Adult 1 |       |  |
| Signatures Required | •              |       |  |
|                     |                | Date: |  |
| •                   | Parent/Adult 2 |       |  |

Authority: Titles XIX and XXI of the Social Security Act. Completion of this form is required to enroll in a health plan. Policy Studies, Inc. (PSI) is the Administrative Services Contractor for CoverKids, under contract with the Division of Insurance Administration.

When you have filled in the application completely, send it with any required documents to:

CoverKids P. O. Box 2010 Cleveland, TN 37320-2010

### Permission to Release Protected Health Information:

I agree that my [and my child(ren)]'s information can be exchanged between CoverKids, Tennessee Department of Human Services, Tennessee Inspector General, TennCare and other State or Federal Agencies and their contractors. The following information can be shared:

- Social security numbers
- Income information
- Eligibility information, which includes information about where I live:

whether I have health insurance;

whether the person applying for CoverKids is an U.S. citizen;

who lives in my house;

Health information.

Contact Name:

This information needs to be shared in order to check my eligibility for CoverKids and/or denial or eligibility for other State and Federal programs including TennCare, Medicaid and other Title V programs such as Children's Special Services programs. Additionally, this health information may be used for audit purposes and the conducting of CoverKids business, which may include making payments to my healthcare provider and evaluating the performance of a health plan or healthcare provider.

The income information provided on this application cannot be used by the Internal Revenue Service (IRS) for tax purposes or by the Bureau of Citizenship and Immigration Service (BCIS) to deny the applicant admission to the U.S., to harm my or my family's permanent resident status or to deport my family or me.

I agree on behalf of myself (and my child(ren), if applicable) to share the information listed above. I understand that I do not have to sign this form, however, if I do not sign this form or if I take back my permission, CoverKids may not be able to determine if my child(ren) is/are or I am eligible and may deny my or my child(ren)'s eligibility to receive said benefits. I see the information on this agreement and understand that I can receive a copy of this signed agreement upon request from CoverKids' Administrative Contractor, Policy Studies, Inc. (PSI) at 1.866.620.8864. I understand that this Release is valid for a period of one year from the date this application is signed. However, this Release may be withdrawn in writing at any time prior to the expiration date; but the withdrawal will not affect any actions taken by any authorized recipient before the withdrawal was received by them.

I understand that if the person or organization authorized to receive the information is not a health plan or a health care provider, the information released may no longer be protected by federal privacy regulations,

| I have read, or have had read to me, the above information, and understa used.   | nd how my protected health information is to be |
|--|---|
| Signature of Applicant if over 18 years  | Date  |
| Signature of Parent/Guardian/Authorized Representative*  | Date  |
| *Authorized Representative means you have legal proof you can act applicant who may not legally sign on his or her own. We may have to get |   |
| Signature of Spouse or other parent in home  | Date  |
| FOR OFFICIAL USE ONLY  |   |
| Applicant's Account Number (This number will be assigned by PSI):  |   |
| Name of certified entity assisting with application:   |   |
| Certified Entity Identification Number:  |   |

Contact Telephone Number: